DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 3548

Registration District No. 5-5 Primary Registration District No. 6262 Registrar's No. 5-6

WRITE PLAINLY—USE UNFADING BLACK INK

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**1. PLACE OF DEATH:**
(a) County NEW MADRID
(b) City or town Gideon — Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution / In this community 25 yrs. (Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MO (b) County NEW MADRID
(c) City or town GIDEON — RURAL
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME DANIEL JOHN EFFINGER
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife CLARA EFFINGER
6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased JUNE (Month) 14 (Day) 1884 (Year)

8. AGE: Years 56 | Months 6 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace EVANSVILLE (City, town, or county) IND (State or foreign country)
10. Usual occupation FARMER
11. Industry or business

MOTHER FATHER
12. Name FREDERICK EFFINGER
13. Birthplace (City, town, or county) IND (State or foreign country)
14. Maiden name HARRIET CLARK
15. Birthplace (City, town, or county) IND (State or foreign country)

16. (a) Informant's own signature Viola Effinger
(b) Address Gideon, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-1941 (Month) (Day) (Year)
(c) Place: burial or cremation Stanfield
18. (a) Signature of funeral director Lloyd Linsell
(b) Address Gideon, Mo
19. (a) Feb 17 1941 (Date received local registrar) (b) Elizabeth Mann (Registrar's signature) acting

(Licensed Embalmer's Statement on Reverse Side)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month JAN day 3 year 1941 hour 11 1 minute P. M.
21. I hereby certify that I attended the deceased from 1-3-41, 19__, to 1-3-41, 19__; that I last saw h[illegible] alive on 1-3-41, 19__; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death | |
| Due to Myocardial Failure | 1 |
| Due to Generalized arteriosclerosis and acute subendocardial Hypotension | |
| Other conditions (Include pregnancy within 3 months of death) | |

PHYSICIAN — Underline the cause to which death should be charged statistically

Major findings:
Of operations
Of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature J. E. Hopkins (M. D. or other)
Address Gideon, Mo Date signed 1-3-41

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RECEIVED
District Health Officer No.
District File Number 241-2
Date Filed 2/19/

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

No. 2B
2-21-40
X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 3548

Registration District No. 55 — Primary Registration District No. 6262 — Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. **PLACE OF DEATH:**
(a) County New Madrid
(b) City or town Anderson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. **USUAL RESIDENCE OF DECEASED:**
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Daniel John Eftinger
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 56 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month June day 3
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Myocardial failure
Due to Coronary occlusion
Due to General arteriosclerosis
Due to Chronic arterial sclerotic Hypertension
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations 94 K
Of autopsy

**PHYSICIAN** — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Dr. Hopkins (M. D. or other)
Address Date signed 5-9-41